HIT Standards Committee
Implementation Workgroup
Transcript
January 22, 2013

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning everybody. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Standards Committee's Implementation Workgroup. This is a public call and there is time for public comment on the agenda. The call is also being recorded so please make sure to identify yourself before speaking. Excuse me. I'll now go through the roll call. Liz Johnson?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Liz. Cris Ross?

Christopher Ross – Mayo Clinic – Chief Information Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Cris. Anne Castro?

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Anne. John Derr?

John Derr, RPh – Golden Living, LLC

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks John. Tim Gutshall? Joe Heyman? David Kates? Tim Morris? Stephen Palmer? Sudha Puvvadi? Wes Rishel?

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Wes. Ken Tarkoff? John Travis? Micky Tripathi? Gary Wietecha? Rob Anthony? Kevin Brady? Tim Cromwell? And Nancy Orvis? And, are there any ONC staff members on the line?

Scott Purnell-Saunders – Office of the National Coordinator

Good morning, this is Scott Purnell-Saunders.

MacKenzie Robertson – Office of the National Coordinator

Thanks Scott. Okay, I'll turn it back to you Liz and Cris.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Thank you. So, excuse me. This morning, and I'm not sure if it's – there it is, there's an updated presentation out here from Scott. What we want to start now is working on clinical scenarios. This will be – I think there's been sort of a hybrid approach developed, between the scenarios that we did originally and where we want to go and I think we'll leave it to Scott to do that explanation. And that is our work for this morning. Cris, would you like to add to that?

Christopher Ross – Mayo Clinic – Chief Information Officer

I don't think so. Let's walk through the materials.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President
Okay. So Scott, we will turn to you.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services
Great. On the agenda I also indicated if there were any additional comments that need to be made from the Standards Committee meeting last week, just leave a couple of minutes for that, if you wanted to do that first, or are you guys okay?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President
I think we're okay, but I certainly would not make that decision independently. Anyone on the workgroup or Cris? I think we added everything we wanted to last week, but I want to make sure that all of you feel the same.

John Derr, RPh – Golden Living, LLC
I feel the same.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare
Okay John, I like that.

Christopher Ross – Mayo Clinic – Chief Information Officer
It's fine. Did our report sound like our work?

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst
Yes.

Christopher Ross – Mayo Clinic – Chief Information Officer
That's the important bit.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President
There you go. I believe that the silence is unanimous, or the silence and affirmative comments are unanimous, we move on.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst
The silence actually woke John up, so …

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President
And we know for Wes and John, it is early.

John Derr, RPh – Golden Living, LLC
Yes.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services
Okay. Great. Let's get started. So the presentation that was sent out, we can start on slide one. I'm actually trying to get on the webinar, but I'll just run it from my PowerPoint directly. So slide one just has an introduction of what we're talking about for the 2014 edition test scenarios. Slide two just has a content list showing what the original, where we're coming from and where we're going to, just describing what each slide is. If we'll continue to slide three. So basically, this is, you know, our initial starting point and the reason why we developed the test scenarios. Essentially, it follows directly in line with what we talked about beginning last spring and last summer to one, make clinically relevant testing scenarios to try to ensure interoperability and ensure interoperability with a data in a system and data across systems. The biggest concern that we've had thus far from input that we've received on the original development of our testing scenarios was to ensure that the proper information could be passed inside a system and also outside a system where you're going between various clinical systems and looking at the scenarios that we've developed thus far.
We'll continue on slide four. We'll look at the completed work. So essentially, we've developed four narrative test case scenarios, the inpatient, ambulatory, emergency department and the medication management. Those were the four that we started last spring and last summer, and received a lot of your input on to revise and update. Essentially, they were developed against the 2011 edition certification criteria, as was indicated in each individual scenario. So we had our listing of what certification criteria

they qualified for, how they were going to be implemented and where … we're going to call a broad scope here. So, they looked at one individual setting here, so an inpatient setting, an ambulatory setting, an emergency department setting and a medication management test case. They were specific to setting and patient data that listed just in that particular area and they were narrative, so they didn't have a particular procedure or a direct process of how the testing would be done. Essentially those original testing scenarios told a story, and that's kind of what we wanted to get done, to develop scenarios that looked like they could connect to each other, tell a story that worked and was relevant in the clinical…in an operational clinical environment, and that made sense. So, we received your input on those and tried to refine those as best we could.

Our current work, if you continue on slide five, shows that we're developing testing scenarios that are actually operational, so they're not just clinical, they're not just narratives, they aren't just stories that we're developing thus far, they're actually procedures that will, that can be passed on to a testing lab and certification body and used in practice as we're building those out. So, the three that were listed here, excuse me, the one that was listed here is the EHR interoperability piece, the intake and then ordering and medication management, as we'll get into at about slide thirteen or fourteen. One, they're developed against the 2014 edition testing criterion. It's a focused scope, so it's not quite as, it doesn't cover as many certification criterion as the original narratives that were developed and they're generalizing scenarios against the specificity as determined by the individual unit test. The unit test is determined by the certification…sorry, the test procedures that were already developed and posted in late December. So, we're using the actual posted scenarios in … I mean procedures, excuse me, in the scenario development to ensure that they can be passed forward to the testing labs and used in certification. The documents include, as we're listing here, the unit test list, scenario diagrams, scenario narrative, the scenario procedure and the scenario test data. These five things listed under the documents include lists are essentially the five pieces that are in each individualized test procedure that was developed and posted, and as those test procedures are updated, the correlating test scenarios that we're building now will be updated to reflect the changes listed there. Any questions thus far?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

I have a question. So here we seemingly are using scenario and what we would call test scripts, are those two words interchangeable in your mind, Scott.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Yes. So, the workgroup has thus far used test script a lot, to indicate the development of a test procedure. We try to always use procedure, in this case, and I do apologize because it's going to get a little confusing in a little bit because what we've … we're coining the test scenarios that we developed before is now a test scenario procedure. The addition of the word procedure was added there to indicate that it can be passed forward to a testing lab and certification body and used, in its entirety, for testing, so it follows a particular procedure and follows the same format of the test procedures that were developed. But test script, as you guys are using, as we sometimes use on this call, and test procedure are exactly the same thing.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay, I'm not sure I'm with you, but I get the words … I don't … others may be further along that I am. Just keep going and see if we can put it together.

Christopher Ross – Mayo Clinic – Chief Information Officer

Just real quick Scott, what's the language that NIST is using about this? I don't even know if that's the right question, but I guess, is everyone using this nomenclature consistently and how do we expect the testing labs, certification bodies to present this.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

So they're still using the term test procedures. So, everything that we've posted and listed officially in this program for the actual procedures is a procedure. So, some people use the term script just so they…like a test script and test procedure are exactly the same thing. The testing labs and certification bodies use that same nomenclature as well, and how we're developing these scenarios to fit that same test procedure format so that they have something that they are familiar with. So they don't have to use, you know, a developed narrative and interpret how they would best apply that in testing, it can be used in its

entirety, from top to bottom with all the necessary tests, all the additional data that needs to be added for crossing between one unit test and a second unit test. So, it can be actually replicated across all the test labs, so you get some succinct reliability between them, instead of having one test lab do it one way and one do it another way. We understand that the test scenarios are something that are optional, and that we're trying to build in this interoperability piece into our program. So, it's not something that vendors are required to go through, but we're trying to develop it as best we can to encourage them to use it in such a way that once they've passed through these test scenario procedures, they don't have to go back and then retest with the individualized unit test that we've developed and put out there before.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So in the – go ahead Cris, you ask first.

Christopher Ross – Mayo Clinic – Chief Information Officer

Sorry, Liz. So just – I want to make sure that I'm straight on this and hopefully this is helpful for the workgroup as well. So Scott, just as a reminder, so for my regulatory and certification approach, the test procedures or the test script procedure, whatever it's called, that atomistic thing is the piece that's required kind of by regulatory standard and that the scenario procedures still have the roll of rolling up and aggregating those atomistic scripts. But at the end of the day, the certification bodies need to be attentive that each of the individual tests is passed. Is that still correct?

Scott Purnell-Saunders – Office of the National Coordinator

That is still spot on. So the idea with the way that we developed the original test scenarios was to try to figure out a way to roll all those up. In that development process, we also realized that because these scenarios are not required, each individualized unit test must be able to be pulled out and the results must be reliable and be able to be tested against other results that exist. So for example, if a product went through a testing scenario that had – it was assessing against three certification criterion, each of those certification criterions then must be able to stand on its own, even inside the scenario. The data is passed forth from one to two to three, but that if individualized results need to be produced, those can then be available for auditing purposes as well as for verification. So, the goal is to develop these so that they can be used in substitution, but still has the reliability of the individualized test.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

I'm – I think I almost understand it, although I feel still baffled. If I'm a vendor and I'm going through a sequence of tests in order to get certified, I have – there are several places in that overall series of things where I do, where I can elect the scenario as opposed to a bunch of totally self-standing tests. If I get through the scenario, I have been tested to the same degree as if I had done individual tests, but there was less redundant setup for each test because I was allowed to carry information from the prior test forward within the scenario, is that correct?

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That is. There's also one other wrinkle there that some additional preparation may be required as far as preparing the data or information to be passed from one test to another. But the idea is that once the scenarios are fully developed and operational, that it will be one, less burdensome on repeat set up for individualized tests and two, more efficient and quicker so that a product may pass through say a couple of different scenarios and it covers the bulk of the unit test needed for that particular product.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

And why is it optional?

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That's a great question, and that was just what was listed by regulation. So the idea was to introduce this as a way to showcase some interoperability pieces, but to build into this, to build this into the program at this point so that as we move towards the future, the scenarios can be more what becomes standard as opposed to what's optional.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

So – and we think that we'll get uptake on an optional thing because it's more efficient for the vendor in going through the testing.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Yes sir, and it also gives a different level of, commitment may not be the right word, but it shows a different level of know-how I guess, so a product can say, we were tested with these testing scenarios, we can show that there is some interoperability within our system. It adds a different marketing piece for the vendor.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah, I seriously doubt that for vendors passing and don't passing are the two important things, you know, users are very seldom educated sufficiently to fully understand pass and don't pass, much less nuances in the way it's – there may be the odd customer, but … Mayo might understand, but …

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Yeah, Scott, I think the thing I'm struggling with is similar to what I think Wes is saying is that we develop these so that the end product would be more useable in a clinical scenario and I don't hear that. I understand it's optional at this point. I also was confused when you said that in order for these to be appropriate, you have to break out each component individually and I don't understand that at all, why. If we've shown that through the testing, through the scenario, procedure, whatever you called it, that each one of the individual components is met, then why do they also have to be broken out? I don't get that.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

They don't have to be broken out directly, it's more of a, if for example the test was or a product was audited or the testing records were audited, it's to ensure that that individualized test record was in there. So it's to show that if there were fifteen steps to go through in a unit test, those same fifteen steps would be represented effectively in the testing scenario as well. Maybe not in the same way, but that those were all done so the testing can be seen as appropriate and effective.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

What I'm seeing as an example, like this, and this is not necessarily interoperability, but, you create a new patient, you apply some medications, you determine that those medications are shown in the patient medication list. Then you have a choice, under the scenario you attempt to enter an order and find that it is contraindicated. Under the individual testing sequence, you start over, you create a new patient, you enter the meds and then you enter an order and find out. So by going through the scenario you have avoided creating a new patient for the second test and re-entering the same medication data. At the same time, by not constructing those tests in isolation, it's likely that the flow from one test to the next is more likely to seem realistic. And if the particular sequences we use are real clinical scenarios rather than a rather arbitrary list of individual and independent tests, then we hope to make our testing material more understandable to clinicians who might look at them and say, well, that's not what we do in our EHR otherwise.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Right.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That's the goal and as we're trying to get to that point, these are some intermediate steps we're trying to reach. So, it's just to ensure that we develop the initial scenario. And I'll continue to slide six here, so it may try to illustrate a bit better what we are talking about. On slide six it shows the narrative test case scenarios we developed initially, with an empty box. Slide seven shows the individual pieces that were added to that scenario, as we developed the first time, with all the various pieces that kind of rolled up together in the narrative that we discussed. Slide eight shows the test data, as Wes just indicated, passing through each individual test, for example, the same test data would be used for all, in this case, all five of these that are listed here. And then on slide seven, excuse me, slide nine, the individual unit tests that were…that could be pulled out of each of those testing scenarios, the idea being that in, say for example, the first one that's listed the EHR interoperability intake. Our testing scenario, the five unit tests listed on the right-hand side would be covered, in the case of the patient intake, the eight as listed would be covered, ordering and med management has the ten and then the patient output has the two at the bottom. These are going to vary as you develop these, but it's to essentially illustrate exactly what we have been talking about, to not have to force a product to go through repeat individualized tests if it can be passed through dynamically.

Christopher Ross – Mayo Clinic – Chief Information Officer

Scott, this is Cris. So, I think either slide nine or slide ten that's got the exclusion piece on the bottom, maybe if you could just describe slide, call-out on the bottom of slide ten and then I've got some comments.

Scott Purnell-Saunders – Office of the National Coordinator

Sure. So the call-out on slide ten is saying that the testing scenarios, so, it's more of…we're developing it with an iterative process, and as we'll get to in a few minutes, at slide fourteen and fifteen and sixteen, we'll kind of illustrate a more real-world example of that. I do have to warn you that it is a bit complex and has way too many boxes, but we'll try our best to get through it slowly. The call-out is that some of the individualized tests that are used in the scenarios are going to vary. So, it's not a – as the individualized scenario – as the scenarios are developed, one may cover five or six different unit tests, one may cover six or seven unit tests, one may cover three or four, depending on what is needed.
If we were to, for example, skip down to…I'll show you slide twelve if you want to get down to slide twelve quickly, that's the original diagram that looked at the scenario-based testing that we talked about last spring, where the scenario covered the individualized unit tests in any prescribed order that were necessary. But if one test didn't work or was not applicable for that particular product, it could be removed from the particular testing sequence and that test scenario could still continue, as opposed to having to re-set up everything that was talked about before. So the call-out that is present on slide nine and slide ten essentially calls that out as being a capability or possibility, saying that the scenarios that we developed are not going to be absolute and set in stone for every particular product or environment that it's presented to or for.

Christopher Ross – Mayo Clinic – Chief Information Officer

So Scott, this is the second time we've walked through this slide, Scott previewed this for Liz and I before we scheduled this meeting, and I think I'm finally getting it, and it's making more sense. I think the thing that I don't want to be too picky here, but, this is a complicated process that requires some precision and I'm finding that the nomenclature, the fact that we're using different words to mean the same thing, really a problem. And I'm feeling like we need to have a clear definition of this, maybe I'm the only person here, but I think we need to have a clear definition of what exactly is the unit test and what exactly is a test scenario which is an assembly of unit tests and we need to use the language consistently throughout. I don't know what a narrative test case scenario is as opposed to a test scenario, for example.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Understood.

Christopher Ross – Mayo Clinic – Chief Information Officer

And I don't know what a unit test is compared to a, let me go further up, what a test procedure is and I just think we need to be more precise about this, because if we're having trouble understanding this, I think others in the system may as well.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Yeah, I would agree. And I would say if you went back to slide five, if you look at just the documents there and trying to differentiate even as we're talking through this with you, we're struggling. So, the idea that these documents and concepts should be able to stand independent of conversation, I don't think we're there yet and like Cris, I mean I think it is clearer to me than it was last week, but it is by no means something that I think I could anywhere come close to explaining to someone else.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Okay. And I think that that's part of the reason why I wanted to present it to the group today. This is something that is certainly in development and I appreciate your time last week in trying to get this…trying to walk through it the first time and get some additional things added that will make it more clear. But, certainly simplification is going to be done as soon as possible, as well as ensuring that the same nomenclature is used throughout to ensure that we're on the same page of music throughout the process. So just to do one explanation, the unit tests are what are included in the individualized test procedures. So, the 2014 edition certification criteria and test procedures were posted in December. Each of those has a particular unit test that's associated with that particular procedure. So when we look at med list, med allergy, problem list, they refer to the exact, specific certification criterion that was posted for that.

The narrative test case scenario that I'll revise the language on that so it's not as cumbersome, is what we were working on or are currently working on now in developing the testing scenario. And then looking at the individualized test scenarios are the smaller ones that can be included in the larger test scenarios that we're building or developing.

Christopher Ross – Mayo Clinic – Chief Information Officer

So, I think this workgroup can get it and continue to be helpful in this, if, again, I'm just trying to confirm this, the unit tests are given to us by the standard. They have been posted, they're not things that you want us to edit or change …

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

No sir.

Christopher Ross – Mayo Clinic – Chief Information Officer

… take as given and then our job is to try to take that as a given and assemble these narrative test case scenarios that encompass these unit tests in a meaningful way. And then I'm wondering if – is that correct so far?

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That is correct.

Christopher Ross – Mayo Clinic – Chief Information Officer

And so then the last question is just the test data piece and whether you're still – if ONC is still looking for comments or input on the test data from the Implementation Workgroup.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

So, half right, not necessarily all.

Christopher Ross – Mayo Clinic – Chief Information Officer

Usually – that's my status most of the time.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

I mean, I'm working with you; we're going to get it done. So yeah, the unit tests are included and were provided, one. The narrative test case scenarios are what – or test scenario procedures, as we'll get to in a second, are what we need your feedback and input on, as we develop this throughout the next few months or so. And three, we'll need input on the test data that's included in the test scenario. So, in the test scenario procedure that I will…I'm previewing now, I'm going to send it out to the group once we get off the call, I'm not going to scare you just yet, Liz and Cris already got that scare Friday, so we'll talk about that in a few minutes. But, there needs to be additional data added to those test scenario procedures to ensure that the data and information can be passed from one test to another. So, that's part of what we'll need some feedback on, as well as just, kind of a…more of a gut check to kind of say, okay, this looks right, we think this will work or can work in a clinical scenario, similar to what we did before. But, there's going to be a very short turn-around time on the small one that we're developing now, just because, as we've been talking about it and developing this, we want to get this in testing as soon as we can, once we know that it's going to be correct and effective. But, if there's also feedback that there is no way this can work and does not fit any of our settings thus far, that would be hugely valuable feedback to us as we move forward to try to develop this and work this out in the next few weeks.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So are you saying – wait, go ahead Cris.

Joe Heyman, MD – Whittier IPA

This is Joe. I'm sorry, I got on just a little bit late, and if you've already explained the difference between the narrative test case scenario and the test scenario, don't do it again, but I'm completely confused.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

I'll be honest with you Joe, I think we're all confused and I don't think it hurts to explain again, because I think it's like we're still trying to absorb and able to commit to you Scott, that we think we can do this work.

And I have to tell you that this on slide ten is different from the list on slide five, so, it does, as Cris pointed out, we do continue to struggle with which piece are we talking about.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Oka. So, the narrative test case scenario that we looked at on slide five, with what was done under the completed work column, and what we're looking at under slide ten, is essentially what slide five was and what we developed initially is what we're building to now. So it's the combination of what was…what's on the left side and what's on the right side. So what was encompassed under the narrative test case scenario for "X" setting was what we did before. We then combined all of that, so for example, the five that are listed here, EHR interoperability, patient intake, patient interaction, order med management and patient output is the combination of the smaller test scenario procedures that we're developing now and how they would roll into the larger one that we developed last spring and last summer, and worked on this fall. So, this box and how it's calling out is basically trying to bridge the gap of where we were to where we're trying to get to. So now, and I don't want to confuse folks completely, but let me skip down to slide…actually, I'll skip down to slide sixteen and I apologize of the order here, but go to sixteen. Now this is what, for example, the narrative test case scenario would look like for ordering and med management, as a procedure. So it shows, and each one of these larger boxes, each test procedure or each unit test, and how it would be done, in a particular prescribed order to effectively be representative of an ordering and medication management scenario as a whole.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay, stop for just a second Scott. Tell us what the numbers mean on this diagram, the 1, 2, 3, 4 through 10. What are those numbers?

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Those are referring specifically to the test procedures or the number of, like for example, how they are identified in the, give me a second, so, I'm sorry, go back to slide thirteen. That's how these numbers are identified and the linking of the unit tests. So, on slide sixteen, it's just showing, for example, going from, if we started with number one, which was the med list, and then went from number one to number two, they both went into nine, going to the drug-drug drug allergy check, which also takes a feed in from CPOE going down to eRx, going down to drug-drug formulary and then that feeds into number nine as well. So the numbers here, and the problem with the way this was designed initially is, if we go, so not to confuse you more, go to slide fourteen, that's probably the most simplified version of this that we're looking at currently. This is the one that we're working on right now where we show going from a smaller step into, like for example, starting with the med list and the med allergy list and the problem list. So you have 1, 2 and 3, all three of those then leading down to the clinical info reconciliation, but that was linked or added to the receive display and incorporated from step four.

Christopher Ross – Mayo Clinic – Chief Information Officer

This is …

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So it's …

Christopher Ross – Mayo Clinic – Chief Information Officer

Sorry Liz, we keep running into each other…

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So sorry …

Christopher Ross – Mayo Clinic – Chief Information Officer

Scott, this is Cris. So, the items that are in blue – are those the test scripts or test procedures?

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That's correct. That's the (a)(6) is the med list, (a)(7) is med allergy, (a)(5) is the problem list. And those are the unit tests that are actually included in the test procedures for each one of those listed individually. So the way that this was designed and laid out was to link all five of these together into this EHR interoperability intake procedure.

Christopher Ross – Mayo Clinic – Chief Information Officer

And what do the small arrows mean as opposed to the darker arrows and could you also do just a description of the numbers, for example. I think, unfortunately, we've got to be really precise about this.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

I understand, so …

Christopher Ross – Mayo Clinic – Chief Information Officer

Yeah, thank you sir.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

No worries. So, if we look at just under box one with the med list, the med list is reconciled and then the med list then feeds down into the EHR.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Hey Scott, stop just for a second. When you say the med list is reconciled, are you saying, a reconciliation takes place as part of a unit test?

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That's correct.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. And then that reconciled list then moves into step 5.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That's correct, into (b)(4) clinical info reconciliation.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

And the same thing happens with med allergies and the same thing happens with problem list.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That is correct.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. And then all of those input then come together under clinical information reconciliation, which is sort of self-evident, and then what is the step at the bottom.

Scott Purnell-Saunders – Office of the National Coordinator

So that's saying the … receive, display, incorporate of a C-CDA is added into that as well, so the med list, under C-CDA, the med allergy list under C-CDA and a problem list under the C-CDA is then added into the clinical info reconciliation.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Well what happened to the one that – I don't mean to be, maybe I'm being totally obtuse, I don't know, but, it looks like to me that you're – by the way you've labeled inside the center box, which is under the number five …

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Um hmm …

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

… did you combine both one … the information, we're just going to stick to the med list only, did you combine the information of the med list reconciled in one and the information received through the C-CDA in box four into five.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That's correct.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay, well, because that's not what this diagram shows. Okay, that makes … because it appears, just visually, that the med list came from the C-CDA, which is why it's is hard to put all this together, at least for me.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

I understand, and the idea with this, and certainly we can make some refinements so it's more transparent and easier to read, is trying to figure out what combination of unit tests could be used to reflect a reasonable clinical workflow. And I do, like I said, I apologize for the complexity of this and some of the confusion on how this looks, but the goal is to build this out so it can, in fact, stand-alone without the necessity for the explanation here, and this does help us try to refine this as we move forward.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

And then tie this to the scenario. I mean to me, this is just a unit test, it is an interoperability unit test, but it's not tied to any scenario.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

So this would be, for example, this piece, even though – so you may look at it as a single unit test, it's five different tests that are currently happening together, which is a very, very small example of a scenario. So, it's not exactly nearly as big as we developed last year and earlier this year, but this is just a small piece of what would happen in one of those. So to start with one of these where we feel one, we know it's predictive and two, we know it's reliable, we would then design this or design a scenario that reflects this workflow as one that does exist inside a clinical operation currently, develop that out so that it can be tested against and then use that in testing. And once we have this as a base, this can be used to build more complex scenarios as we move forward.

Joe Heyman, MD – Whittier IPA

This is Joe. I am so sorry, but I am just totally, maybe this is just out of my league. But, that middle box, the one that says clinical info reconciliation, what added thing is there on med list that wasn't in the first box. I mean, what is the – what's the difference? What happens there that doesn't happen in the first box with med list?

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

It's combined with the information from box four.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

It's combined with the information from the C-CDA, Joe. So what I think they're saying is, I'm at the door, I'm presenting you with a med list. As a clinician, I'm also privy to, so to speak, information from the C-CDA and this test shows that the software has the ability to combine those two. I think that's what you're trying to say, Scott.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That is.

Joe Heyman, MD – Whittier IPA

And, if that's the case, why do you need the first part? I mean, it seems to me that, I mean, no physician is going to reconcile it twice on the same day…

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Right.

Joe Heyman, MD – Whittier IPA

… so, I …

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

… and once the reco – right, he is right. So unless the reconciliation can take one place, and that is related to box 5 …

Joe Heyman, MD – Whittier IPA

Exactly.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

… then we're not in a realistic clinical scenario.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Got it. And that's – honestly, that's the kind of feedback we need to see.

Joe Heyman, MD – Whittier IPA

So, let me just say that for me, just looking at this off the top of my head, my diagram would only have that middle box.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Okay. What would feed into that middle box though?

Joe Heyman, MD – Whittier IPA

All the information would feed into the middle box, but in the workflow, the only box would be the middle box.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Okay.

Joe Heyman, MD – Whittier IPA

Either that or I would have four boxes, without the middle box, and have the CDA feeding into each of the four boxes. But maybe – I'm just looking at this as a clinician.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

You – we are, both of us are Joe. I think what Scott's saying is, in order to, which is the part that I'm confused by too, but I understand what the words are saying, which is, for audit purposes, for testing audit purposes, it must be proven that each of the individual tests were performed as part of the composite. So I think, Scott, that's – one of the things that's very confusing here is that, from a clinical perspective, one would only want to deal with five and everything else would have happened. From a testing and software vendor perspective, all these things needed to happen to get us to five for us to use.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

This is Wes. I wonder if I can propose a slight modification to the words you used Liz …

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Absolutely.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

… and see if Scott agrees with them. For audit purposes, it needs to be shown that when someone creates a narrative – completes a narrative test, all the same things have been tested for as if they had completed all of the individual tests. That's subtly different than saying to show that they completed all the individual tests, but in effect, but it says, there was no loss in testing fidelity based on using the narrative rather than the five individual tests, whatever the number is. Scott, is that accurate?

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That is.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So help me understand the subtly Wes.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay, so there are – if the number is five tests …

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Right.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

… I'm kind of lost on this slide right now, but if the number is five tests and one scenario, then there are actually six tests.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Right.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay, one of them is the scenario, it has a set-up, a series of steps and an end state that you validate, okay. Each of the individual steps is similarly a test in that it can be run free-standing, that is, in testing now I'm finding that people generally seek independence of the test, so that they don't have to run them all…they don't have to run the last dozen tests in order to run the thirteenth test. That means that each of the five tests has a set-up, a set of steps and then an outcome to be verified. Now obviously, for the one test that is the whole scenario, the set-up is probably a little more complex and the number of steps is certainly – and the individual steps is certainly more complex, the outcome, the validated outcome might be, but it doesn't involve redoing set-up five times …

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

… you do that once.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

I got you.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

All right. Now, at the end of that, an auditor wants to be satisfied that in doing the five "X" step, which was much more efficient in terms of people's time, you didn't just leave anything out that would have happened…leave anything significant out that would have happened if you'd run the five individual tests. So, effectively they're saying, the easiest way to create an … scenario would be not to test for everything, right, I mean, that would be highly efficient, in terms of time, but, they want to be able to demonstrate that everything that was verified in each of the individual tests is also verified in the scenario test. But they don't want to demonstrate that they repeated each individual test, so, it's the outcomes that are verified rather than the actions of the testing.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So, I understand that. Scott, is that a correct description, because if it is, it makes sense.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That is, and also along with that is the additional of the data pieces that we're adding to ensure that the information can be passed from one small unit test to another small unit test.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

And I have a feeling the triangles are the data.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

That's correct.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

So, it's showing that data does exist for each of those to go from one portion to another. So, if you go back to slide thirteen. Slide thirteen pretty much tries its best to explain it. I'm going to – I'll pause for a second before I – you know, you guys ask what is one, two and five, what is one, two, five, three, five and six.

Joe Heyman, MD – Whittier IPA

I'm sorry, before you leave this slide. When you have the first box one, and it says med list and there's a thing with a little arrow that says reconciled, to me when you recon – and this just shows how confused I am, to me to reconcile a med list, there are three things. There's the meds that are already listed in the EMR from the last time you saw this patient, there's the med list that's coming from the CDA and then there's what the patient tells you. Those are the three things. And the way you reconcile it is, you use the patient or the patient's family, to explain to you what you think is going on, and maybe you also use some pharmacy history, I don't know. Now to me, that's the only process that actually happens in the workflow, there's no other process. And I don't understand how that – I don't understand why that – I can't figure out how that is tested when you break it up into little pieces. I just don't, I don't get it.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

I don't think, so anyone please correct me if I misread this, I don't think that they're breaking it up into little pieces for the purposes of actually running the test, the full scenario, I should say. I think they're breaking it up in pieces for the purposes of ensuring that if it's a … that we can assure ourselves that all pieces of the test have been done, not for the actual application of the scenario. So, it takes all the steps, but the scenario would be, as you said, the result is the center box, but all the steps have to take place to get us to the center box. Does that make sense Joe, kind of …

Joe Heyman, MD – Whittier IPA

I guess so. I guess the thing that I'm saying is, there's only one reconciliation and that's in the center box.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Right. Yes, just from the requirements to get the test scenarios …

Joe Heyman, MD – Whittier IPA

Right.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

… how it's built. Okay, so, it's about twelve 'til and Scott, I know that we need to sort of get through this presentation and also understand what we're doing next, so, shall we keep moving?

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Yeah, let's do that. I'll ask the group if there are, once folks have had a chance to try to digest this a bit better post the call, if there are individual or group questions, just send me a note and we can talk about it further. I will be refining this based on some of the feedback received today and received Friday. So, hopefully I can just forward a more transparent presentation to everyone. If we go to slide seventeen and slide eighteen. Seventeen basically looks at our goal for this process and this effort thus far. We understand there's not a ton of time. What I'm going to do post this call is forward out the draft version of the updated test scenario procedure that we were discussing today that reflects what was presented on slide fourteen for the most part, to the group. So, folks can take a quick read at it.

Part of the sidebar that we had during the call with Liz, Cris and myself was that scenario that was developed is about sixty pages. Before folks get upset at me, essentially it's a combination of the five test procedures that were already developed, that are represented in that scenario, combined into a single document which shows every individualized test that needs to be completed, along with the data that needs to be added to that, for those tests to be done in a successful manner and in succession. So the data pieces that were added, and updated steps need to be added for each test to occur and then the proposed results that were present at the end. So, I will be – go ahead Liz.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Yeah Scott, I was going to say, one of the questions that we asked was, and that helps us how? Because it sounds like what we did, and you haven't answered for this Scott, but what it sounds like when you hear that at first, or at least what it sounded like to me, was that just meant we took a bunch of stuff and clumped it together and now we're calling it a scenario.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

And that's not necessarily the case. What we did in this scenario was to combine…pull out the unit tests that are reflected in the scenario, combined them in a way that makes sense clinically, and show how the data needs to be passed between one test and another, to show an actual workflow that would be present in a clinical environment. So, it's not just simply putting five random procedures together, adding a bit of duct tape and glue and saying, we hope for the best here. It's to ensure that it reflects what actually happens and goes on. We understand that we can't develop nearly every combination of unit test into individualized testing scenarios, just because there are so many combinations that are going to be present. We talked about this when we did our initial kind of pass at this before.

And our goal is, once we can get a few of these done and vetted and operationalized, that other people from the public and vendors can come in and say, I propose a scenario that looks like this, that has a combination of tests that we haven't done before, that fits these particular requirements. And once vetted through ONC and reviewed, can be added into the testing program. Our goal for this is to have some feedback back on the draft that I'm going to send out today, with some updates, before January 31, so that we can post it online to receive public comment and feedback. You're more than welcome to comment on the version that we put out on January 31, certainly if we can get feedback before then, that's going to be helpful for us as we try to accelerate this process a bit. We're going to also have meetings with the – some focus groups from the testing labs and cert bodies to discuss this process as well and to try to have a pilot of this developed scenario thus far with at least one, some vendors or one or two vendors that can do this, to ensure that it works.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

And then slide eighteen is just basically our work plan for the next – until the end of February, so it basically shows our meeting that occurred today at the top in purple, sorry for the size, I know it's a bit small. And then our next meeting, which is next Monday on January 28 as well and then Thursday the big date, as everything kind of indicated in red is when we're trying to post this draft.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So our job going forward, and we do need to talk – I think also what's confusing is the way you've labeled the scenario, I wouldn't call this intake, but we'll work on that.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Okay.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So what our job is, you're going to get us out this actual procedure and we're going to … or test scenario as you called it, and we will read it, provide, ask questions via a group email so that we're all not getting the same questions answered over and over, and be ready to do what on Monday, what is the goal of Monday if we're trying to release this next Thursday, or a week from Thursday?

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

So the idea with the call next Monday, once you've, if anyone – when people have had a chance to look at it, to give me your honest opinion, just like you did with this presentation today. It will give us a chance to do some potential refinements by or before next Thursday, before we put this up for the public and it's certainly possible that the approach that we're looking at with this may be more confusing to those…than that on this call, which indicates something different. So, we need to try to go back to the drawing board and either refine it to make it more simple or pull some things out so it can actually be understood a bit better potentially by the public. But, we want to use the workgroup as we can to give us a first pass and say hey, we're not as close to it as you are, but we feel like these are some areas that can be improved upon before this goes out.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Christopher Ross – Mayo Clinic – Chief Information Officer

Scott, that's really helpful and I know we've been pretty tough in this conversation, but I think we're trying to be tough on the subject, not on you. This is hard, detailed work and we really do appreciate it and, this is intended to be a conversation amongst friends.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

Well, I do call all of you friends and I appreciate the candor.

Christopher Ross – Mayo Clinic – Chief Information Officer

Yeah, I know we beat you up.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

It's fine, I'm used to it, so, as I indicated Friday, and a couple of times, we're asked to present and produce things that aren't always easy. If it was easy, everybody would do it, so, this is fine.

Christopher Ross – Mayo Clinic – Chief Information Officer

There you go.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

I'm so glad I work under nice co-chairs.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Yeah, really. Yeah, it really was a good job Scott. And it's incredibly … it is easier to see it the second time than the first, I can offer the workgroup some assurance, and Scott, thank you for working on it over the weekend. I know you weren't supposed to be working, so we appreciate your work. I think we need to go to comments and then we will be looking forward to you getting this out to us this week, so that we'll be hopefully between our email conversations and our meeting on Monday, be able to add some more depth and color to it before it goes out for public comment on January 31. So MacKenzie, will you take us to comments please?

MacKenzie Robertson – Office of the National Coordinator

Sure. Operator, can you please open the lines for public comment?

Caitlin Collins – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Well thank you all, and especially thank you Scott for trying to get us to, something that you've probably spent a very long time thinking about and you've done a really nice job of trying to get us all much closer to you in just an hour, so thank you. And thank you to all the workgroup and I guess we'll look forward to next Monday with lots of work in between. Cris?

Christopher Ross – Mayo Clinic – Chief Information Officer

Nothing more to add. Thanks for a good, substantive conversation.

John Derr, RPh – Golden Living, LLC

And, this is John, I'll be on a plane tomorrow … next Monday, going to that meeting we're having in D.C. on Tuesday.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Actually, so will I.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay, well please, in the meantime, once you've had, if you had a chance to look at it, if you'll send us any comments that would be really helpful both of you. But thank you for letting us know.

John Derr, RPh – Golden Living, LLC
Okay. Bye.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President
All right, thanks everybody.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services
Thank you. Bye, bye.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President
Bye now.

Christopher Ross – Mayo Clinic – Chief Information Officer
Bye, bye.